ROSELLE SCHOOL DISTRICT NO. 12
School Medicine Authorization Form

To be completed by the child's parent(s)/guardian(s) and kept in the school nurse's office or, in the absence of a school nurse, the Building Principal's office:

Student's Name:		Birth Date:
Address:		
Home Phone:	Emergency Phone:	
School:	Grade:	Teacher:

To be completed by the student's physician:

Physician's Printed Name:		
Office Address:		
Office Phone:	Emergency Phone:	
Medication:		
Dosage:	Frequency:	
Time medication is to be administered or under what circumstances:		
Prescription date:	Order date:	Discontinuation date:
Diagnosis requiring medication:		
Intended effect of this medication:		
Must this medication be administered during the school day in order to allow the child to attend school or to address the student's medical condition? ☐ Yes ☐ No		
Expected side effects, if any:		
Time interval for re-evaluation:		
Other medications student is receiving:		

_____ _____
Physician's signature Date

For parent(s)/guardian(s) of students who have asthma:
I authorize the School District and its employees and agents, to allow my child or ward to possess and use his or her asthma medication (1) while in school, (2) while at a school-sponsored activity, (3) while under the supervision of school personnel, or (4) before or after normal school activities, such as while in before-school or after-school care on school-operated property. Illinois law requires the School District to inform parent(s)/guardian(s) that it, and its employees and agents, incur no liability, except for willful and wanton conduct, as a result of any injury arising from a student's self-administration of medication (105 ILCS 5/22-30).

If you agree please initial: _____
Parent(s)/Guardian(s) initial

By signing below, I agree:

1. That I am primarily responsible for administering medication to my child. However, in the event that I am unable to do so or in the event of a medical emergency, I hereby authorize the School District and its employees and agents, in my behalf and stead, to administer or to attempt to administer to my child (or to allow my child to self-administer, while under the supervision of the employees and agents of the School District), lawfully prescribed medication in the manner described above. **I acknowledge that it may be necessary for the administration of medications to my child to be performed by an individual other than a school nurse, and specifically consent to such practices**, and
2. To indemnify and hold harmless the school district and its employees and agents against any claims, except a claim based on willful and wanton conduct, arising out of the self-administration of medication by the pupil.

Parent/Guardian printed name	Parent/Guardian printed name
Parent/Guardian signature* Date	Parent/Guardian signature* Date

** Both parents and/or guardians, if available, should sign.*